



Medicines optimisation (MO) is a patient centred approach. It focuses on gaining the most benefit for patients from their medicines. It is all about talking with the patient, having honest discussions with them and truly making them part of the decision in relation to their medicines and the use of their medicines. It is about understanding the patient's goals and aspirations, which may be different from the outcomes the NHS would like to see, listening to their concerns and beliefs about medicines and about stopping or reducing medicines as well as starting new ones.

Regardless of which sector you work in, taking a patient centred approach to optimising medicines and improving patient outcomes should be a priority.

What am I already doing to support medicines optimisation?

- In hospital pharmacies the dispensaries are mainly led and run by pharmacy technicians enabling pharmacists to spend more time with patients on the wards or be involved in activities such as outpatient or specialist clinics. This is where pharmacists should be so they can undertake pro-active discussions with patients about the use of their medicines.
- Pharmacists and their teams lead the medicines reconciliation service which means you are involved in optimising the medicines for the individual patient, reviewing and making sure the medicines are right for that patient. This may also involve discontinuing medicines that are causing problems or are potentially detrimental to the patient.
- Pharmacists are often involved in the discharge of patients and you spend time explaining any changes in medicines to the patient including provision of information about new medicines such as adverse drug reactions to look for and what action to take. You may signpost patients to appropriate support post discharge.
- If you are a hospital pharmacist prescriber you have a direct role in ensuring the right medicines is chosen for the patient in relation to safety and available evidence. Pharmacist prescribers and patients are equal partners when making decisions about medicines and discussions should include details of benefits and risks before a joint decision is made to initiate or discontinue treatment. We believe the majority of hospital pharmacists should be prescribers.
- You may be involved in the provision of specialist services such as aseptics, ensuring optimum doses of chemotherapy are prescribed, prepared and administered or medicines information, providing advice and support on medicines to patients and other health professionals based on the best evidence available.
- You may be involved in the training of pharmacy staff and other health professionals within the organisation to ensure they play a full and active role in MO.

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What am I already doing to support medicines optimisation? cont.

- You support patients to use their own medicines to reduce risk by improving the medicines reconciliation process and preventing waste.
- Every day you use your professional judgement to make and influence important changes to drug therapy to prevent harm to patients.
- You influence your colleagues in the wider clinical team in relation to the use of medicines, undertaking roles such as mentoring, training of medical and nursing staff etc.
- You have a role in local decision making to ensure that patients have access to safe and effective medicines, such as those recommended by NICE or by spreading best practice through local formulary guidance.
- You are patient advocates, ensuring that the systems and processes within your organisation are designed to meet the best interests of all patients. You encourage patients to be involved in decision making about their own care and wherever possible in the design of services for others.
- You signpost patients to local support groups and patient support services to support them to take their medicines.
- You are involved in and actively contribute to an integrated patient safety management system; you report, and encourage members of the public to report, adverse drug reactions using the Yellow Card System and make records of any incidents and near misses. The learning from these help to improve medicines safety and thereby improve patient safety.

What more could I do?

- Pharmacists working in hospitals often have advanced clinical knowledge in specific disease areas and this could be shared more readily with colleagues in other sectors to enable these colleagues to provide improved clinical services for patients.
- Clinical pharmacy services could be provided outside of the hospital in outreach centres, care homes, patient's own home and other settings which are closer to the patient.
- The role of the hospital pharmacist in supporting patients with their medicines often finishes at the point of discharge. Pharmacists and their support staff should be involved in every discharge to help patients understand any changes to their medicines and undertake an assessment of the patient's ability to adhere to their medicines. There should be a handover, in relation to the medicines, to community pharmacy colleagues and active liaison with managers and nurses running the discharge services. Follow up should be encouraged.
- Pharmacists should consider how the patient will cope when they are at home and make appropriate interventions to reduce any risks that exist. Consider any potential post discharge support you could offer such as follow up telephone calls or visits as well as signposting to appropriate support in primary or social care.
- Pharmacists should be involved in the assessment of a patient's needs in relation to their supply of medicines, such as the need for support tools like large print labels, wall charts and **multi-compartment aids**.

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What more could I do? cont.

- You should be considering the simplification of medicines to enable patients to self-manage and encourage independent living including a critical assessment of all medicines which may result in discontinuation of medicines as well as starting new medicines.
- The pharmacy department should be undertaking audits to minimise missed doses on the wards. Explore what work is being undertaken within the hospital to reduce missed doses and consider what you and your team can do to lead or support improvement.
- Hospital pharmacy staff should be more involved in drug administration rounds and encourage patients to self administer their medicines on the wards which in turn helps with
- the patient assessment prior to discharge and ensures the patient does not become deskilled in relation to taking medicines during their admission.
- If a patient has a long term condition (LTC) and is on a care pathway could you be more involved in ensuring the patient has access to the medicines they need as part of that pathway?
- If a patient has recently moved from one care setting to another consider what additional support you can provide to them about any changes to their medicines. Could you potentially keep 'individual management plans' up to date in regard to any changes in medicines? How do you liaise with the interface care team if appropriate?
- Do you encourage patients and / or their carers to take a copy of their discharge letter to their usual community pharmacist or to seek help, advice or support from them?
- Consider what data you already capture, what you could capture in the future and what value this may have in data provision for the wider NHS.
- Are you linked in with your Local Pharmacy Network (LPN) and aware of the work programmes they are taking forwards?

How can I work with my pharmacy colleagues to support the patient?

Pharmacists, as a profession, are unique in that they see the medicine across the whole of the medicine pathway – from development to supply to the patient. However, medicines optimisation means that the pathway doesn't stop at the point of supply and considers how patients use their medicines in practice, including short and long term outcomes.

Reflection

- Did I discuss with any patients today their experiences of medicines use prior to discharge? For example, their views about what medicines mean to them, how medicines impact on their daily life, whether or not they are able to take their medicines, what information they actually want to know? Did you listen to the patient's views and opinions?
- Do I know who my community pharmacy colleagues are in my locality?
- Did I refer any patients to a local community pharmacy for an MUR or NMS?

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Reflection. cont.

- Did I ensure medicines used are clinically and cost effective? For example did I review any 'high risk' patients' medicines? Did I make patients aware of the consequences of not taking their high risk medicines? How is this information recorded and shared?
- Am I aware of the latest NICE guidance and Quality Standards?
- Did I record any data to contribute to the evidence base around medicines optimisation?
- When did I last contact a colleague in a different care setting (e.g. community, intermediate care, care home, GP practice) to help a patient optimise their medicines and make them as safe as possible?
- Did I signpost any patients to sources of additional support for medicines use?
- How do I share any learning or best practice findings? Am I involved with my local networks such as LPFs or LPNs?
- On reflection were there opportunities to apply the principles to my practice that I may have missed?

Why should I deliver medicines optimisation?

- It provides you with a chance to have a positive impact on a person's health and quality of life and enhance the patient's experience of care.
- You will be positively involved in patient safety, medicines adherence and preventative care.
- You will empower patients to better self manage their condition(s).
- It provides you with an opportunity to support effective medicines use and minimise medicines waste.

How will my professional leadership body support me to deliver MO?

- We will work with the other professional bodies and Royal Colleges to support the understanding of medicines optimisation across all health and care professionals
- We will particularly work with employers and other pharmacy organisations to ensure the environment is right to enable delivery of medicines optimisations services
- We will liaise with national bodies such as NHS England and NHS Employers on how the contract could change to enable better delivery of medicines optimisation
- We will work with NHS Improving Quality to look at innovative ways of delivering medicines optimisation
- We will work with social care organisations to explore how medicines optimisation can be delivered in social care settings
- We will appraise and assess knowledge and skills of pharmacists via the RPS Faculty

We are all aware that the NHS spends significant amounts of money on medicines each year; in 2012 the NHS invested £13.8 billion pounds across the UK. We also know that 30-50% of patients don't take their medicines as intended and that around 1 in 20 admissions to hospital are related to adverse drug reactions. This can lead to ill-health, poor quality of life, loss of productivity and a waste of NHS resources that is simply unacceptable.

Additional reading

1. [RPS medicines optimisation webpages](#) which contains the following resources:
 - a. Helping patients to make the most of medicines Good practice guidance for healthcare professionals in England
 - b. How to make the most of your medicines – guidance for patients
 - c. Examples of medicines optimisation services and activities
 - d. Medicines optimisation – the evidence in practice
 - e. Medicines optimisation – the evidence in practice presentation
 - f. Medicines optimisation briefings for the different sectors of pharmacy
2. [RPS guidance Keeping patients safe when they transfer between care providers – getting the medicines](#)
3. [RPS map of evidence which has examples of good practice across the country](#)
4. [RPS Professional Standards for Hospital Pharmacy Services: Optimising patient outcomes from medicines](#)
5. [WHO: adherence to long term therapies](#)
6. [Medicines Optimisation and Pharmaceutical Services Framework – please contact Richard Seal for a copy](#)